

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS639HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/18/2010
NAME OF PROVIDER OR SUPPLIER SUNRISE HOSPITAL AND MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3186 S MARYLAND PKWY LAS VEGAS, NV 89109		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 156 SS=G	<p>NAC 449.332 Discharge Planning</p> <p>14. If identified in a discharge plan, referral of a patient to outpatient services or transfer of the patient to another facility must be accomplished in a manner that meets the the identified needs of the patient, including the sharing of necessary medical information about the patient with the receiving service or facility.</p> <p>This Regulation is not met as evidenced by: Based on record review and interview, facility staff discharged a patient that needed additional care in an unsafe/improper manner.</p> <p>Patient #3 was transferred with blunt head trauma to the facility at 2:42 PM on 12/30/09. Patient #3's file contained several indications he needed an ENT consult. A physician wrote an order to transfer the patient to a second facility for this purpose on 1/1/10. On 1/2/10, a physician note indicated a case manager was working on an ENT consult. On 1/3/10, a physician note indicated the patient was waiting for a transfer to the second facility for an ENT evaluation and another indicated a case manager was working on obtaining an ENT evaluation. A third note indicated "here vs. transfer [to the second facility] for evaluation." On 1/4/10, a physician noted the lack of ENT availability at the facility and noted the second facility would not accept a transfer because the patient lacked insurance. The physician offered to discharge the patient with directions to go to the emergency department of the second facility. On 1/4/10, a physician noted two different times to discharge the patient once case management gave the patient bus/taxi fare to get to the second facility. The facility discharged the patient on the morning of 1/5/10. The discharge diagnoses included seizures vs. syncope, alcohol use, tobacco dependence, fall, traumatic brain injury, right temporal bone injury,</p>	S 156		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 156	<p>Continued From page 1</p> <p>right hemotympanum, posttraumatic intracranial hemorrhage, resolved leukocytosis, and improved headache.</p> <p>The second facility admitted the patient at 2:08 PM in its emergency department on 1/5/10. The record indicated the patient brought himself to the second facility without any documentation from the facility. At 2:45 PM on 1/5/10, the patient indicated the following: "I was instructed to come to [the second facility]. I was a patient at [the facility]. I was told there was no ENT doctor at [the facility], so they discharged me after 6 days and paid for the taxi cab they sent me here in." The facility's director of case management denied this ever occurred, but the facility's discharge instructions indicated someone at the facility provided a taxi voucher. The second facility admitted the patient at 3:58 PM on 1/5/10. A physician diagnosed the patient with right temporal bone fracture, right facial nerve palsy (new diagnosis), and seizure disorder. Neurology consulted and eventually cleared the patient for discharge with Valproic Acid. ENT consulted and recommended steroids to be tapered after a week and to follow up in Lied Clinic. The patient was discharged with Prednisone 10 mg, Dilaudid 2 mg, Ofloxacin eardrops, Valproic Acid, and Artificial Tears. The second facility requested records from the facility on 1/5/10 and 1/8/10. The patient stayed 5 days at the second facility and was discharged on 1/10/10.</p> <p>On 2/19/10 at 9:30 AM, Physician #1 felt discharging Patient #3 enabled Patient #3 to get to the second facility more quickly, and Patient #3 was relatively stable. Physician #1 indicated it was difficult to unrealistic to secure an ENT consult at the facility despite an active roster of ENT physicians. Physician #1 claimed some</p>	S 156			

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S 156	<p>Continued From page 2</p> <p>physicians were contacted to consult, but he failed to indicate physicians by name.</p> <p>A list of active, credentialed physicians indicated the facility had associations with 16 ENT physicians. On 2/19/10 at 9:45 AM, each physician's active status was verified with the supervisor for physician credentialing. Ten of the physicians were contacted. Eight of the physicians indicated they were never asked to consult on Patient #3's case. The other two physicians were on vacation during Patient #3's stay. One of these two physicians, Physician #3 on vacation, indicated he did not have to see any patient if and when asked.</p> <p>The facility had a reciprocal facility transfer agreement in effect with the second facility at the time of the aforementioned event. According to the agreement, the facility only transferred a patient due to medical necessity. Medical necessity was defined as services required to be provided to a patient with an emergency medical condition which are provided at the receiving facility but are not provided at the transferring facility for ANY patient and which are not provided to any patient at any other facility within the transferring facility's system. According to the second facility, the neurologist for Patient #3 indicated the ENT consult was viewed as non-emergent in this case, and the second facility denied the transfer as a result. Therefore, the facility would have violated the reciprocal agreement by transferring the patient. According to facility policy #ADT0106, and last revised in May 2007, "transfer to another facility may occur if a particular service is not provided at [the facility]. The policy failed to allow for transferring a patient because physicians refused consults to see patients or because facility personnel failed</p>	S 156			

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S 156	Continued From page 3 to ask physicians to provide needed consults. Ultimately, the facility failed to provide the care recommended, and failed to discharge/transfer the patient properly. The facility discharged the patient knowing the patient needed additional care the facility was capable of providing. The second facility eventually referred Patient #3 to one of the same eight ENT physicians facility personnel never contacted to request a consult (Physician #2). Scope: 1 Severity: 3	S 156			
S 300 SS=F	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to provide individualized care based on the assessed needs of 2 of 3 patients by failing to contact physicians to provide an ENT consult (Patient #3) and failing to administer ordered Benadryl for at least an hour and forty-four minutes after a Vancomycin reaction (Patient #2).	S 300			

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S 300	Continued From page 4 Severity: 2 Scope: 3	S 300			

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